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April 3, 2009

MEMORANDUM

TO:

Legislative Oversight Committee Members	Commission for MH/DD/SAS
Local CFAC Chairs	State CFAC
NC Council of Community Programs	NC Assoc. of County Commissioners
County Managers	County Board Chairs
State Facility Directors	LME Directors
LME Board Chairs	DHHS Division Directors
Advocacy Organizations	Provider Organizations
MH/DD/SAS Stakeholder Organizations	NC Assoc. of County DSS Directors

FROM: Tara Larson

Leza Wainwright

SUBJECT: Implementation Update #55

CSC Assumes DMA Provider Enrollment	Utilization Review Update
Reimbursement of Behavioral Health Services	Revised Guidance for Endorsement Appeals
Time Limit Overrides	Changes to DHHS Incident Reporting
Completing POC and CNR Requests	PCP Signature Page Check Boxes
Authorizations for Recipient Transfer	Clinical Coverage Policy 8A Q&A

Computer Sciences Corporation to Assume N.C. Medicaid Provider Enrollment, Credentialing, and Verification Activities

The Division of Medical Assistance (DMA) is pleased to announce that Medicaid provider enrollment, credentialing, and verification functions will be transferred from DMA Provider Services to Computer Sciences Corporation (CSC) in late April 2009. This change will result in timelier processing of provider enrollment applications and will increase the support available to providers in need of assistance with enrollment and maintenance activities.

Please note that Electronic Data Systems (EDS) will continue to perform all other provider support functions. Providers will continue to call EDS for claim status, checkwrite information, billing problems, etc., just as they do today. At this time, CSC will assume responsibility for only provider enrollment, credentialing, and verification activities.

Effective April 20, 2009, providers will mail all Medicaid enrollment forms, including applications, agreements, Medicaid provider change forms, and Carolina ACCESS applications and agreements, to CSC at the address shown in the chart below. Providers accessing the DMA website for enrollment information after April 20, 2009, will be redirected to the CSC website to obtain provider enrollment forms.

CSC will operate a dedicated Medicaid Provider Enrollment, Verification, and Credentialing (EVC) Call Center for providers to inquire on the status of their Medicaid applications or change requests. The EVC Call Center hours of

operation will be 8:00 a.m. to 5:00 p.m., Monday through Friday, except for State approved holidays. The toll-free CSC telephone and fax numbers are shown in the chart below.

Calls to the EVC Call Center will be answered by representatives who specialize in provider enrollment and credentialing functions. CSC will log and track information captured during the call in order to ensure consistent quality of all inquiry responses. CSC's goal is to resolve inquiries during the initial call. If additional research or escalation is necessary, a response and resolution will be provided within 48 hours of receipt of the call.

The EVC Call Center will be staffed with experienced health care professionals who will provide support in the following areas:

- Enrollment and credentialing processing
- Change request processing
- Enrollment, verification, and credentialing status
- Obtaining appropriate forms and instructions
- Assistance with forms completion
- Website support for down-loading forms and instructions

CSC will accommodate many methods of provider communication including telephone, e-mail, fax, and written correspondence. All correspondence coming through the EVC Call Center will be maintained in a central repository to allow easy access and quick retrieval of provider inquiries.

Beginning in April, CSC will also initiate a process to verify information for currently enrolled Medicaid providers. In accordance with CMS requirements for Medicaid participation (42 CFR.455.100 through 106), CSC will initiate credentialing activities for those enrolled providers who have not been credentialed in the last 14 months. CSC will notify providers when verification and credentialing activities will begin for their provider types.

DMA and CSC will continue to inform providers of various events and changes through the general Medicaid Bulletin, the DMA website, and the CSC website to ensure a smooth and seamless transition of enrollment, credentialing, and verification activities.

Beginning April 20, 2009, the CSC website can be accessed at http://www.nctracks.nc.gov. In addition to enrollment forms and enrollment/credentialing information, the website will also include instructions for completing forms, frequently asked questions, and other information to ensure that providers are well informed in advance of submitting applications.

EVC Call Center Contact Information

Enrollment, Verification, and Credentialing Call Center Toll-Free Number	866-844-1113
EVC Call Center Fax Number	866-844-1382
EVC Call Center E-Mail Address	NCMedicaid@csc.com
CSC Mailing Address	N.C. Medicaid Provider Enrollment CSC PO Box 300020 Raleigh NC 27622-8020
CSC Site Address	N.C. Medicaid Provider Enrollment CSC 2610 Wycliff Road, Suite 102 Raleigh NC 27607
CSC Website Address	http://www.nctracks.nc.gov

Refer to DMA's website at http://www.ncdhhs.gov/dma/provider/mmis.htm for more information about CSC and the development and implementation of the Replacement Medicaid Management Information System (MMIS).

Reimbursement of Behavioral Health Services

1. Currently **licensed behavioral health providers** are able to utilize the following H codes:

Code	Description
H0001	Alcohol and/or drug assessment
H0004	Behavioral health counseling and therapy, per 15 minutes
H0004 HQ	Behavioral health counseling and therapy, per 15 minutes group setting

H0004 HR	Behavioral health counseling and therapy, per 15 minutes family/couple with client present
H0004 HS	Behavioral health counseling and therapy, per 15 minutes family/couple without client present
H0005	Alcohol and/or drug services; group counseling by clinician (15 min=1 unit)
H0031	Mental health assessment, by non physician

See the appropriate fee schedule located at: http://www.ncdhhs.gov/dma/fee/index.htm

2. **LMEs** are also able to utilize the H codes listed above to bill for the services of provisionally licensed providers until June 30, 2009. Please monitor future Implementation Updates as to the future status of this option.

3. Previously providers were notified in Implementation Updates # 43 and # 44 that effective July 1, 2008 physicians could bill for services of the provisionally licensed professionals "incident to" the physician using CPT codes and codes H0001, H0004, H0004 HQ, H0004 HR, H0004 HS, H0005 and H0031. Please note that a March 2009 Medicaid Bulletin article "Behavioral Health Services Provided by Provisionally Licensed Professionals in Physician Offices" which can be found at http://www.ncdhhs.gov/dma/mp/ amended that guidance and after May 1, 2009, only the appropriate CPT codes (with the SC modifier) may be utilized to bill for provisionally licensed professionals providing services "incident to" the physician. **Please note that the March 2009 Medicaid Bulletin article does not apply to licensed professionals or LMEs billing H codes for provisionally licensed behavioral health professionals.**

Time Limit Overrides

Federal guidelines require that all Medicaid claims, except hospital inpatient and nursing facility claims, must be received by EDS within 365 days of the first date of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the last date of service on the claim. If a claim was filed within the 365-day time period but not paid for some reason, providers have 18 months from the remittance advice (RA) date to refile a claim.

If the claim is a crossover from Medicare or any other third-party commercial insurance, regardless of the date of service on the claim, the provider has 180 days from the date listed on the explanation of benefits (EOB) to file the claim to Medicaid from that insurance (whether the claim was paid or denied). The provider must include the Medicaid Resolution Inquiry Form, copy of the claim, and a copy of the third-party or Medicare EOB in order to request a time limit override with EDS.

Claims initially received for processing within the 365-day time limit, may be resubmitted to EDS on paper or electronically. The claim information must match exactly to the original claim for the recipient Medicaid identification number (MID), provider number, from date of service, and total billed. Claims that do not have an exact match to the original claim in the system will be denied for one of the following Explanation of Benefits:

- **0018** - Claim denied. No history to justify time limit override. Claims with proper documentation should be resubmitted to EDS Provider Services Unit.
- **8918** - Insufficient documentation to warrant time limit override. Resubmit claim with proof of timely filing — a previous RA, time limit override letter, or other insurance payment or denial letter within the previous six months.

Requests for time limit overrides must be sent to EDS with documentation showing that the original claim was submitted within the initial 365-day time period. Examples of acceptable documentation for time limit overrides include:

- Dated correspondence from DMA or EDS about the specific claim received that is within 365 days of the date of service
- An explanation of Medicare benefits or other third-party insurance benefits dated within 180 days from the date of Medicare or other third-party payment or denial.
- A copy of the RA showing that the claim is pending or denied; the denial must be for reasons other than time limit.

Examples of unacceptable documentation may include, but not limited to:

- The billing date on the claim or a copy of an office ledger.
- The date that the claim was submitted does not verify that the claim was received by EDS within the 365-day time limit.

The **Medicaid Resolution Inquiry Form** is used to submit claims for Time Limit Overrides. The instructions for completing the Medicaid Resolution Inquiry Form can be found in the Basic Medicaid Billing Guide at http://www.ncdhhs.gov/dma/basicmed/ in Section Eight – Resolving Denied Claims on page nine.

When submitting inquiry forms, always attach the claim and a copy of any paper RAs related to the inquiry form, as well as any other information related to the claim (provider generated RAs or electronic RAs are not acceptable). Each inquiry

request requires a separate form and copies of documentation (vouchers and attachments). Because these documents are scanned for processing, attach only single-sided documents to the inquiry request. Do not attach double sided documents to the inquiry request. A copy of the Medicaid Resolution Inquiry Form is on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.

Retro Eligibility and Retro-Active Prior Approval
In some instances an application for Medicaid benefits is initially denied and then later approved due to a reversal of a disability denial, a state appeal, or a court decision. A time limit override may be needed in some cases; the county department of social services (DSS) is responsible for requesting this override based on date of approval. When a time limit override is warranted, the county department of social services will provide written notice to the recipient outlining the specific dates of service when the Time Limit Override is approved. Recipients are instructed to immediately notify the provider of retroactive approval. When this occurs, providers can file claims for these specific dates of service outlined in the recipient letter. The provider must file these claims within six months of determination as outlined in the recipient letter.

Retroactive prior approval is considered when a recipient, who does not have Medicaid coverage at the time of the procedure, is later approved for Medicaid with a retroactive eligibility date. Because some of these appeals and reversals are not final for many months, the county DSS can request an override of the claims filing time limit from DMA.

Timelines and Completeness of Plan of Care and Continued Need Review Requests for DD Services

Timeliness
Case managers are to submit Continued Need Reviews (CNR)/Plans of Care (POCs) for CAP-MR/DD recipients by the first day of the birth month. If such falls on a weekend or holiday, the CNR is due on or before the first day of the month (not on the first business day of the month). See http://www.ncdhhs.gov/mhddsas/cap-mrdd/value-options-timeline-update-12-4-06.pdf. The documentation required for each CNR/POC is a current psychological evaluation (or concurrence review/documentation), NC SNAP (full document) and other assessments to support the POC/CNR document. Please refer to Implementation Update 42, dated April 07, 2008 which provides additional detail on the requirements for submission of a POC/CNR document.

When a CNR/POC is submitted to ValueOptions after the first day of the birth month and corrections or additional information are required, depending on the submission date and the turnaround of the additional information the approval of the CNR/POC may not occur before the expiration of the previous authorization. This contributes to frustration for recipients and families, in addition to unnecessary time and effort for all involved. Each month ValueOptions provides DMH/DD/SAS a list of case managers and agencies who submit late CNRs; LMEs should be requiring those providers to implement corrective action plans to ensure recipients receive services in a timely manner.

Thank you to agencies who submit documents on a timely basis.

Completeness
Over 25% of the CNR/POC submissions are missing documents, a rate that is unchanged since Implementation Update #48. An incomplete submission for a recipient age 21 and over will be returned to the case manager as Unable to Process and the case manager must resubmit the entire request. An incomplete submission for a recipient under age 21 will be handled under Lack of Information procedures. A list of required documents is found at http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm.

Note that ValueOptions cannot authorize targeted case management without a current Person Centered Plan (PCP) in place. The case manager is to submit the PCP once annually or as the condition of the individual warrants an update.

Per Implementation Update #48, the Comprehensive Waiver contains an annual cost limit of $135,000. Requests for individuals on the Comprehensive Waiver with an annual cost that exceeds $135,000 will be returned to the case manager as Unable to Process. The Supports Waiver contains an annual cost limit of $17,500. Requests for individuals on the Supports Waiver that exceed $17,500 will be returned to the case manager as Unable to Process.

ValueOptions Fax Lines for DD Requests

DD initial and concurrent requests	919-461-0669
DD additional information requests *only*	919-461-4935
DD urgent requests *only*	919-461-0679

Examples of urgent requests: imminent loss of home/residential placement, crisis services, respite due to emergency (e.g. primary caregiver incapacitated).

For greatest accuracy, fax one recipient's request per fax. List the number of pages and the transmission date on the fax cover sheet.

Submission of Correct Forms
Providers are to use current forms: Comprehensive Waiver Cost Summary and Supports Waiver Cost Summary at http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm. CTCM form at: http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm.

Case Managers should mark at the top of the MR2 either "Comprehensive Waiver" or "Supports Waiver."

Transition of Medicaid Recipients to New Provider and Authorization Process
In circumstances when the provider of record fails to submit a discharge Inpatient Treatment Report (ITR), new providers have had difficulty obtaining an authorization for a consumer who has come to them requesting the same service. There are four situations in which this may arise as a barrier to a consumer's receipt of necessary services. They are: 1) A consumer switches providers due to choice; 2) The Local Management Entity (LME) withdraws endorsement and consumers must change providers; 3) The provider voluntarily discontinues the provision of services without prior notice to the LME and consumers must change providers; and 4) The provider voluntarily discontinues the provision of services giving notice to the LME and consumers must change providers.

When consumers change provider agencies due to choice, and the previous provider of record has not sent the discharge ITR to the utilization review (UR) vendor,* the following processes have been approved to minimize barriers:

1. The new provider will request that the provider of record send a discharge ITR to the UR vendor within 48 business hours of the new provider's request. Keep in mind that the required authorizations for the exchange of information must be in place.
2. If the provider of record does not provide the UR vendor with the discharge ITR, the new provider contacts the LME (where the site/service of the provider of record is located). Keep in mind that the required authorizations for the exchange of information must be in place.
3. The LME investigates the situation to determine facts and subsequent actions to be taken.
4. If the new provider's claim is verified, the LME instructs the provider of record to send the discharge ITR to the UR vendor within 24 hours.
5. If the provider of record fails to provide the discharge ITR to the UR vendor, the LME arranges for the LME director, or his/her designee**, to email the UR vendor with an end date for the current authorization.
6. The LME determines whether corrective action is required of the provider of record and handles accordingly.
7. The new provider may submit the request for authorization to the UR vendor*.
8. In cases where a complete request was sent to the UR vendor by the new provider and denied as unable to process due to the existing authorization, the new provider can either:
    - Contact the UR vendor's customer service and ask that the request be re-opened; or
    - Re-fax the original request with the original confirmation of receipt of submission.

When a provider discontinues a site/service, either voluntarily or through withdrawal of endorsement:

1. If the LME was unaware of the provider's discontinuation of services, the LME investigates the situation to determine facts and subsequent actions to be taken.
2. When the LME determines that the consumers of a particular provider site/service require transition to a new provider, the LME director, or his/her designee, notifies the UR vendor* of the end date of the current authorizations for the provider's sites and services affected.
    - When the termination of services occurs through the loss of endorsement (voluntary or involuntary), the LME shall send a copy of the Notification of Endorsement Action (NEA) letter withdrawing endorsement to the UR vendor* at the same time that the NEA letter is sent to DMH/DD/SAS and DMA.
    - When there is a discontinuation of services for reasons other than loss of endorsement, the LME director, or his/her designee**, may email the UR vendor* with an end date for the current authorization(s).
3. The LME and/or the provider of record assist with the transition of consumers to a new provider using provider choice guidelines.
4. In the event that a new provider has submitted a request for authorization before the LME has notified the UR vendor, #8 above may be followed.

* Currently the sole UR vendor is ValueOptions, LMEs wishing to notify ValueOptions of providers that have lost endorsement and requiring authorizations to be end-dated should email PSDProviderRelations@ValueOptions.com.

**There may be only one individual from each LME authorized to perform these communications with the UR vendor. That individual shall be the LME director or designee. The name and contact information of that individual shall be provided to the UR vendor*.

Utilization Review Update

DMA and DMH/DD/SAS continue to work cooperatively with the selected local management entities (LMEs), ValueOptions and EDS to move toward the July 1, 2009 implementation date. This is being done through weekly conference calls as well as special training events. During the week of March 23rd, all parties attended a four-day training event on the clinical and technology basics of utilization review. On April 2nd, there was a day devoted to planning the transition and testing phases of the project. Currently, DMA and DMH/DD/SAS are in the process of planning training for the first week of May that will cover medical necessity, documentation and other advanced utilization review topics.

Revised Guidance for Endorsement Appeals

The most recent Endorsement Policy: "Policy and Procedures for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA Services", December 3, 2007, contains guidance regarding the appeal process on pages 9 and 10, Section 8 "Reconsideration and Appeal Rights of the Provider."

In order to ensure that providers are aware of the two different appeal processes the policy is being revised to read:

Community Support Appeals:

If the Notification of Endorsement Action letter indicates a denial or withdrawal of endorsement for Community Support Child and/or Community Support Adult services, to appeal the Community Support Provider Petition must be filed within 30 days of the date of the letter. A copy of the form may be obtained by calling the Department of Health and Human Services (DHHS) Hearing Office at 919-647-8200. Instructions for filing the Community Support Child and/or Community Support Adult Services appeal are on the application form.

Appeals for Services other than Community Support Child and/or Adult Services:

If the Notification of Endorsement Action letter indicates a denial or withdrawal of endorsement pertains to any services other than Community Support Child and/or Community Support Adult, the appeal must be filed with the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services within 15 days of the date of the Notice of Endorsement Action letter. Appeal rights are set out in G.S. 122C-151.4 and in administrative rules at 10A NCAC 27G. 0810.

For questions about the appeal process for services other than Community Support, contact the DMH/DD/SAS Operations Section at 919-715-2780.

For questions about the appeal process for Community Support or the petition, please contact the DHHS Hearing Office at 919-647-8220.

Changes to the DHHS Incident Reporting Process - Effective Date: April 15. 2009

Under the Care of a Provider

The definition for "a consumer under the care of a provider" refers to a consumer who has received any services in the 90 days prior to the incident. A peer review is required for Level III incidents if an incident occurred when a consumer was receiving a service or the incident occurred on provider premises. Please see Attachment A, "Clarification of Level III Peer Review" for specific requirements. For Level III incidents that did not occur while the consumer was receiving a service or was on the provider's premises, the responsible LMEs may continue to request detailed information regarding services if this information is not already provided in the incident report. (See Attachment B: Suggested Questions for Level III Incidents.)

Consumer Absences

The Incident Reporting Grid Sheet will be modified to include a Level III category for when an Amber or Silver Alert has been issued. Amber and Silver Alerts must be verbally reported immediately to the LME (Host and Home for a consumer placed out of catchment area) and DMH/DD/SAS Advocacy. Information regarding Amber Alerts can be found at http://www.nccrimecontrol.org/index2.cfm?a=000003,000005,000081,000103. Information regarding Silver Alerts can be found at http://www.nccrimecontrol.org/Index2.cfm?a=000003,000005,000081,001670.

Reporting of Abuse, Neglect and Exploitation

All allegations of abuse, neglect or exploitation must be reported to the appropriate agencies such as DSS and/or Division of Health Services Regulation (DHSR) Healthcare Personnel Registry as required by NC General Statue and NC Administrative Rules.

All allegations of abuse, neglect or exploitation must be documented as incidents in accordance with the below chart:

Level I	Level II	Level III
Any allegations of abuse, neglect or exploitation that occurred prior to enrollment into services.	Any allegations of abuse, neglect or exploitation by anyone, including a caretaker, friend, relative, staff or stranger, that occurred while enrolled in services.	Any allegation of abuse, neglect or exploitation of a consumer that is likely to result in, or may result in, permanent physical or psychological impairment, or arrest; or an allegation of rape or sexual assault.

Additional Requirements Regarding a Consumer's Death by Suicide, Homicide/Violence, Accident, or Unknown Cause (All Level III's)

In an effort to obtain accurate data regarding the cause of death of a consumer, providers must obtain a copy of the medical examiner's (ME) report and /or the autopsy report (or a copy of the death certificate if the other documents are not available). Providers must update the incident report based upon this information even if the cause of death does not change the level of the incident. The incident report form, QM02, can be found at: http://www.dhhs.state.nc.us/MHDDSAS/statspublications/manualsforms/index.htm#incident. Update the incident report by making changes to *Death Due To*: (page 2 of QM02) as indicated in the ME or autopsy report. Formally amend the incident report by crossing out *Unknown Cause* or other cause if changed and checking the actual cause of death. Attach a copy of the aforementioned documents and resubmit the incident report with a comment briefly describing the change. Providers should request this information and submit updated information based on 10A NCAC 2C .0303 (f) (3).

Additional Reporting to the LME and DMH/DD/SAS:

If an incident is likely to be reported in a newspaper, on television or in other media, or if the consumer is perceived to be a significant danger to or concern to the community, the provider is to verbally report the incident to the Host LME and the DMH/DD/SAS Advocacy Team (919-715-3197) immediately upon learning of the incident.

Person Centered Plan (PCP) Signature Page Check Boxes

There have been many questions regarding the use of and the related consequences to completion of the check boxes on the Signature Page of the PCP when ordering Medicaid funded services. There is no penalty for checking either the "yes" or the "no" box on either question. Checking the "no" box does not effect the approval or denial of the submission for authorization. The only consequence associated with this requirement is activated when there is a signature but neither box is checked. A PCP submitted to ValueOptions without the check boxes completed will be considered as "unable to process" for authorization. Only in the case where there is not a check in either box would a qualified professional submit the reporting form to DMA so that a licensure or certification board can be contacted. Information regarding the Signature Page/Check Boxes can be found on page 32 of the PCP Instruction Manual, in Implementation Update #51, and on the DMH/DD/SAS Home Page (in the yellow box).

Clarification Related to the Requirements in the Revised Clinical Coverage Policy 8A

There have been a number of questions related to the revised Clinical Coverage Policy 8A, Community Support-Adult (page 29) and Community Support-Children/Adolescent (page 44) service definitions regarding the requirement for the agency to employ at least one full-time licensed professional. To fulfill this requirement, please see the following questions and answers (Q & As):

Q1: Is it permissible for the full-time licensed professional to be provisionally licensed?
A1: No, to fulfill this requirement, the person must be fully licensed.

Q2: What is considered to be "full-time?"
A2: For the purpose of this policy and in fulfilling the requirements of the service definitions, DMA has defined full time as being 40 hours per week, excluding holidays, vacations, and sick time.

Q3: If an agency cannot locate a full-time licensed person, but could find two who would work part-time, would their combined hours meet the requirement?
A3: No. The policy requires one full time licensed professional, not two part time individuals. Whenever the term, "full-time" is used, it means one person; if it says, "full time equivalent, "or "FTE," then more than one individual may share the position.

Q4: Can the full-time licensed professional be under contract, or does he or she have to be employed by our agency?
A4: Either arrangement is acceptable, as long as the licensed professional is working full time for your agency.

Q5: Is the requirement for a full time licensed professional per site?
A5: No, the requirement is that the organization must have at least one full-time licensed professional in the organization. Therefore, an organization with multiple sites would still only have to have one full-time licensed

professional to meet this requirement. However, the intent it that the licensed clinical staff will serve all sites and that they are responsible for the clinical services being provided.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

cc: Secretary Lanier M. Cansler
Allen Feezor
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMA Deputy and Assistant Directors
Christina Carter
Sharnese Ransome
Wayne Williams
Shawn Parker
Denise Harb

Attachment A

Clarification of Level III Peer Review Requirements
This is not a rule change

(A) Categories A and B providers shall respond to level I, II or III incidents by:
- (1) attending to the health and safety needs of individuals involved in the incident;
- (2) determining the cause of the incident;
- (3) developing and implementing corrective measures;
- (4) developing and implementing measures to prevent similar incidents;
- (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; and
- (6) maintaining documentation regarding Subparagraphs (a)(1) through (a)(5) of this Rule.

(B) In addition to the requirements set forth in Paragraph (a) of this Rule, Categories A and B providers shall respond to a level III incident that occurs while the client is in the care of a provider or on the provider's premises by:
- (1) immediately securing the client record by:
  - (a) obtaining the client record;
  - (b) making a photocopy of the entire record* (up to 12 months prior to the incident, including notes about the incident)
    *Return original record to where it is normally kept so that it continues to be available for use;
  - (c) certifying the copy's completeness with a written statement attached to the copy and signed by an administrator; and
  - (d) transferring the copy to a peer review team;
- (2) convening a meeting of a peer review team within 24 hours of the incident. The peer review team shall:
  - (a) consist of three or more agency staff (who were not involved in the incident), including a peer of the staff who witnessed or was involved in the incident;
  - (b) review the copy of the client record as specified in Subparagraph (b)(1) of this Rule;
  - (c) gather other information needed; and
  - (d) issue a report concerning the incident and the peer review team's findings to the provider and to the client's home and host LMEs to facilitate the monitoring of services as required by G.S. 122C-111 and other State statutes; and
- (3) immediately notifying the following:
  - (a) the host LME (catchment area where the services are provided) pursuant to Rule .0604;
  - (b) the client's legal guardian, as applicable; and
  - (c) any other authorities required by law (DSS, Medical Examiner, law enforcement, DHSR Complaint Unit, DHSR Health Care Personnel Registry, DMH Advocacy).

Attachment B

Suggested Questions for Level III Incidents

The following are suggested questions that the LME might ask the provider unless the information is already listed on the incident reporting form:

- What services was the consumer receiving? Were all services through one provider? If not, who were the other providers? Was the clinical home notified of the incident?
- When and with whom was the consumer's last appointment? If no-shows, was there any follow-up? Did consumer generally attend appointments or were there many no-shows?
- Was there any history of suicidal ideations, suicide attempts or hospitalizations (for reasons other than medical reasons)? Was there any indication of suicidal ideations at last visit? What plan was in place to address suicidal ideations and decrease risk?
- If consumer was receiving medication, when was last visit? Were there any changes to medications? Was consumer taking medication as prescribed?
- Were all services recommended at assessment being provided (e.g. substance abuse evaluation, substance abuse treatment, sex offender treatment, individual therapy, medication evaluation, etc)? If not, why?
- Was consumer receiving medication from any other providers? Which provider was prescribing which medication? If so, was there communication between the providers?